Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum

Module # 7 : Effective Communication

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Module #7: Effective Communication

I. Overview: Communicating effectively both within the interdisciplinary team setting and with older adult patients and their families is a contributing factor to the health care professional's success in both relationships. This module addresses strategies of effective communicators within the team as well as strategies to engage the older adult/family. Examining what attitudes and beliefs the health care professional personally brings to the relationship will also facilitate healthy and effective communication.

II. Learning Objectives:

1. Describe communication barriers to effective teamwork.

2. Delineate strategies to achieve productive, interdisciplinary team discussion.

3. Explain strategies to achieve collaborative problem-solving on an interdisciplinary team

4. Discuss communication barriers in work with older adults.

5. List some useful open-ended questions the clinician can utilize when assessing patients facing life threatening illnesses.

III. Effective Communication in Interdisciplinary Teams

A. Communication Barriers to Effective Teamwork: Particularly in an interdisciplinary setting where team members do not always possess a basic understanding of each other's knowledge and values, it is possible that *misunderstandings will result*. For example, "most physicians equate quality of life with mental status or freedom from mental impairment; many nurses relate quality of life to

physical strength, seeing, hearing, and someone who cares."[1] In addition to differences in disciplinary approaches and terminology, individuals within a geriatrics team tend to *have distinct strengths and weaknesses* related to problem solving and conflict-management. Awareness of each team member's unique approach to reaching team goals is essential to effective communication.

IV. Strategies to Achieve Productive Team Discussion: [1] [2]

A. Techniques that Encourage Communication

1. Encouraging and Reinforcing Responses

a. Be *succinct* and avoid long anecdotes or examples.

b. Make an effort to use positive *body language* such as head nodding, eye contact, and leaning toward the speaker.

c. In order to show interest, *repeat one or two key words from the person's last sentence*. This encourages the speaker to continue talking and enhances his or her sense of being heard.

d. To ensure that the message is understood, *paraphrase and reflect* by repeating a person's statement in his or her own words.

e. Avoid using technical jargon if possible; if a condition is best described in technical terms, however, members should make sure that everyone on the team understands those terms.

2. Questioning Effectively

a. Ask *appropriate and specific questions* of other geriatrics disciplines, and be willing to learn from others.

b. Closed questions should be used to focus on specific problems and elicit limited responses, often just a yes or no. They rarely elicit a lot of additional information, but they are appropriate when specific information is needed quickly.

c. Open questions give people permission to say more about what they are thinking and feeling.

3. Making Decisions

a. *Summarize* discussion points that have been made and check for consensus.

b. Interdisciplinary team members should *discuss how decisions will be made.* At times, decisions may be made by consensus, but the geriatrics team should identify situations when a vote might be needed.

c) When important decisions must be made, each member should be *polled for his or her opinion*

B. Problems to Watch For:

1. There is tension during the meeting, and the sense that there is more going on than meets the eye.

2. Opinions are expressed as facts.

3. Statements that receive no acknowledgement, comment, or response.

4. Negation or discounting of a member's opinion.

5. Defensiveness or withdrawal from the discussion.

6. Reliance on one person to manage the discussion; no shared responsibility for facilitating the conversation.

7. Repetition of points, unsure whether anyone heard them the first time

8. Discussions that are stuck: inability to conclude a discussion on one topic and move on to the next.

9. Frequent digressions from the topic.

10. Discussions in the hallway after the meeting are more free and candid than those during the meeting.

V. Conflict Resolution: Despite all efforts at effective communication, in any team setting, conflict will inevitably occur. Arguments between individual members or within factions of the geriatrics team may arise due to emotional responses, differences in values or conflicts in needs and priorities. These kinds of conflicts occur most often when, in an effort to rapidly reach consensus, individuals of the interdisciplinary team suppress their doubts and allow individuals in high status disciplines to make decisions among themselves.

A. Four Possible Outcomes of Conflict [3]

1. Avoidance: Frustrated parties avoid each other and the issues. This approach usually leads to stagnation and leaves members increasingly dissatisfied.

2. *Capitulation and domination*: One party wins and the other loses. This result prevents the interdisciplinary team from being able to fully utilize all the resources of each member and discourages individuals from contributing to team planning.

3. *Compromise*: Each party relinquishes something important in an effort to meet in the middle. Neither party feels that the solution is the best, and both feel that values and priorities have been lost.

4. *Collaborative problem-solving*: Both parties clearly state their needs, several solutions are developed that address all needs and members of the geriatrics team chose the solution that maximizes gains for all involved. In this case, the interdisciplinary geriatrics team feels as though everyone has won and the most effective plan has been devised.

B. Strategies to Achieve Collaborative Problem Solving [4]

1. Agree on process or protocol for handling disputes before they arise.

` 2. Recognize the problem and agree to address it.

3. Obtain agreement from all parties to move toward a solution: agree on problem-solving process and agree to disagree respectfully.

4. Deal with emotions first.

5. Explain roles of each profession to define the problem in terms of individual needs and to clarify the priorities of each discipline.

6. Do not attempt to deal immediately with the substantive or entire issue.

7. After breaking down issues into smaller sub-issues, deal with each sub-issue one at a time.

8. Avoid temptation to permanently skirt central issues.

9. Show respect for the other person by taking turns speaking. Also give the speaker your full attention and avoid the distraction of composing your response while listening.

10. Be concise and focus on the most important aspects of the issue for you when stating your feelings and views.

11. Be alert to existence of hidden agendas.

12. Brainstorm many possible solutions and avoid censoring suggestions. Make sure all opinions have been heard before selecting the plan from the list.

13. Seek a solution that is consistent with the values of all parties.

VI. Effective Communication in Geriatric Care

A. Overcome Communication Barriers [5]

1. Alleviate Discomfort

a. Make the environment welcoming. Make sure other staff members treat the patient with warmth, consideration, and respect, both in person and over the telephone.

b. *Address the patient by his or her last name*, using the title the patient prefers. Avoid forms of address such as "dear" or "hon," which tend to be impersonal and condescending. Address the patient by his or her first name only if the patient tells you to.

c. *Introduce yourself clearly.* Show from the outset that you accept the patient and want to hear his or her concerns. You might mention looking forward to working together and encourage the patient to ask questions as they arise.

d. *Consider gently touching the patient* on the hand, arm, or shoulder to help set him or her at ease. Some older people expect health care providers to be "hands on," but be aware that this expectation may vary among cultures.

e. *Maintain an unhurried pace.* Because many older people function well only if unrushed, trying to hurry communication can prove counterproductive. Some patients may need additional time to formulate their thoughts, so try not to put words in their mouths. To permit sufficient time, consider scheduling a longer visit or multiple visits.

2. Reduce Language Barriers

a. In addition to being unfamiliar with medical language, older people may be unacquainted with recently coined words, new expressions, or new uses of old words. On the other hand, older patients may use expressions unfamiliar to younger providers. *Use simple, common language and be willing to ask for clarification if needed.*

b. Educational levels of older people are generally lower than those of their children, and even some very intelligent older people may not be functionally literate. Keep this in mind when deciding whether to give written instructions. If an older person whose native language is not English lacks literacy in his or her native language, merely translating written materials will not suffice. Alternatives include *using diagrams and giving written materials to relatives who read.*

c. Rapid-fire questioning and fast delivery of information may intimidate some older people. *A gentle, more empathic style* generally proves more comfortable and productive.

3. Compensate for Hearing, Visual, Speech, and Movement Defects, And Cognitive Disorders (See Learning Resource A "Communicating Effectively with the Elderly")

B. Educating the Older Patient [6]

- *Identify and discuss lifestyle factors* such as diet and exercise that can facilitate or impede the patient's health.
- Some patients refrain from asking questions even if they want more information. Be aware of this tendency and *make information available* even if it is not required.
- *Encourage the patient to ask questions.* Indicate who in addition to yourself can answer questions that arise later.
- *Provide information through more than one channel.* In addition to giving information orally, use or supply materials such as fact sheets, drawings, models, videotapes, or audiotapes.
- *Encourage the patient or caregiver to take notes* and be ready to offer a pad and pencil. Active involvement in recording information may promote retention and compliance.
- *Repeat key points*, both within a given visit and at later visits.
- *Present information in a way that is easy to understand.* Avoid medical jargon, use simple everyday language; break the information into small parts, and use analogies or examples. Avoid overloading the patient with too much information at once.
- *Check whether the patient and his or her caregivers understand what you say.* One good approach is to ask that they repeat the main message in their own words.
- *Provide praise and encouragement when appropriate.* Call attention to strengths that can be built on. Remember to provide continued reinforcement for new treatment or lifestyle changes.

C. Explaining Diagnoses[7]

- Receiving *clear explanations of diagnoses* is critical. When patients do not understand their medical conditions, they tend not to follow the treatment plans. Uncertainty about what is wrong can be disturbing.
- In explaining diagnoses, it is helpful to begin by *finding out what the patient believes is wrong, what the patient sees as its implication, and how much more the patient wants to know.*
- Use these responses as a starting point for *gently correcting misconceptions* (for example, "Many people believe…but actually we are learning that…") and providing appropriate amounts and types of information.

D. Discussing Treatment[8]

- *Be certain that the patient agrees* with the goal or outcome of the treatment plan.
- Keep the treatment plan as *simple and straightforward* as possible
- After proposing a treatment plan, check with the patient about its *feasibility* and *acceptability*, and resolve any misunderstandings.
- Tell the patient *what to expect* from treatment or recommended lifestyle change, what improvement is realistic, and when he or she should start to feel better.
- Unless literacy is a problem, *provide written instructions*. Make sure the print is large enough for the patient to read.
- Indicate the *purpose of each medication* or other treatment.
- Make it clear *which medications must be taken regularly* and which ones the patient may choose to take only when having symptoms.
- Encourage the patient and his or her caregivers to take *an active role* in discovering how to manage chronic problems.

(See Learning Resource B "The Old Woman" by Anonymous—)

VII. Effective Communication in Palliative Care

("Letter to a Patient's Doctor," by Suzanne Gordon. See Learning Resource C)

A. The Prognosis [9]

- Providers have a tendency to overestimate the prognosis. Sometimes it is better to give a range or an average.

- Understanding what the future may hold helps the patient and the family with coping and planning. It also increases access to hospice and other services.
- Reading: "Breaking Bad News: A Six-Step Protocol" by ??? (where is this from?)

B. Goals of Care[10]

- *Avoid using language which makes a distinction* between an aggressive curative intent and giving up. For example, don't say "Do you want us to do everything possible?" or "Will you agree to discontinue care?"
- It is important to develop facility with language that reinforces *the goals of appropriate medical care* for someone with an advanced progressive illness and a life-threatening prognosis. For example, say "We will concentrate on improving the quality of your life," or "I'll do everything I can to help you maintain your independence."
- Whenever goals are uncertain or may change, they should be *reviewed and clarified*. They should be reviewed when there is a significant change in health status, the patient has a limited life expectancy, the setting of care changes, or treatment preferences change.

C. Open-Ended Questions[11]

- Explore the *patient's perception of illness and prognosis* by using open-ended questions and by asking follow-up questions that incorporate the patient's own words
- Open-ended questions are generally useful in *eliciting patient concerns and emotions*. They focus attention on a particular domain of care and may direct attention to frequently avoided, emotionally significant issues.
- Potentially Useful Open-Ended Questions about End-of-Life Care

  "What concerns you most about your illness?"

  "How is treatment going for you and your family?"

  "As you think about your illness, what is the best and the worst that might happen?"

  "What has been most difficult about this illness for you?"

  "What are your hopes (your expectations, your fears) for the future?"

D. Terminology[12]

- Providers sometimes avoid using terms like "hospice" or "palliative care" because they imply that death is imminent, and instead use euphemisms such as "supportive care," "comfort care," or "comprehensive care." *Such terms can be ambiguous and may lead to confusion.*
- Whatever terms are used, both the provider and the patient should share a *common understanding of the terms' meanings*. Specific examples of the elements of palliative care such as "pain management" and "family support" may be useful because they lack a palliative or terminal care label.

VIII. Suggested Readings

Trillin, A. "Betting My Life". November 2001. Good Housekeeping.

McFarlane, R. 1998. *The Complete Bedside Companion: A No-nonsense Guide to Caring for the Seriously Ill.* Chapter 2: Dealing with the Doctors. New York: Simon and Schuster.

Twycross. R. *Introducing Palliative Care.* 1999. Abingdon, UK: Radcliffe Medical Press.

IX. Learning Resources:

Learning Resource A: Communicating Effectively with the Elderly*

Fundamentals for Effective Communication: Requirements for Reaching Understanding

1. Two-way Activity (expressive and receptive)
2. Shared Expectations
3. Shared Reality
4. High Comfort

Techniques for Communicating with the Hearing Impaired Elderly

1. Get the elder's attention first and face the person.
2. Light your face; do not become backlit.
3. Ask if the person is hard of hearing. If yes,

   a. Ask if he/she is wearing a hearing aid. If yes, ask if it is functioning properly. If it is not functioning properly, offer to help by testing the battery or looking at the volume setting.
   b. If the elder is not wearing a hearing aid but is having difficulty hearing, ask if he/she hears better in a particular ear and focus to that side when you speak.
   c. Ask if the elder lip-reads or signs.
4. Speak up but do not shout.
5. Use lower-pitched tones that are heard more easily than higher tones.
6. Speak slowly and clearly but do not overemphasize.
7. Cut out background noise.
8. Keep your mouth in clear view.
9. Rephrase rather than repeat a misunderstood sentence.
10. Use other channels of communication such as gestures, diagrams, and written materials.
11. Have the elderly person repeat vital fact s to insure comprehension.
12. Alert the person when you are changing the subject.
13. If an elderly person has a hearing deficit but does not want to admit it, try to encourage a hearing assessment so that simple situations such as the accumulation of excess ear wax can be uncovered and assistance provided for more complex situations.
14. For those profoundly deaf, the Americans with Disabilities Act of 1990 requires that a sign language interpreter be provided within 10 minutes in an acute care setting and within 20 minutes in an outpatient setting.
15. Remember to utilize services in your community for assistance.

Techniques for Communicating with the Visually Impaired Elderly

1. Always identify yourself clearly.
2. Narrate your activities; inform the elder when you enter or leave the room.
3. Use clear language when giving directions (e.g., use "right" and "left" rather than general terms like "over there;" use "yes" or "correct" rather than "right").
4. Obtain and encourage use of low vision aids.
5. Make sure that the setting is well lit.
6. If an elder is not wearing glasses, ask if glasses are usually worn and for what purposes. If glasses are needed for the intended situation, be sure that the elder is wearing them.
7. Be aware that if an elderly person is pulling away from you or is turning his/her head to one side and seems to be looking away, it may only be to adjust distance and angle to improve ability to see you.
8. When using printed material, make sure that it is a size the elderly person can read (at least 14 point type).
9. Use hearing and touching to reinforce your communication.
10. Remember to use resources within your community for assistance.

Techniques for Communicating with Speech Impaired Elderly

1. Try to find out before interacting with an elderly person if the elder has a speech problem to avoid immediate embarrassment and frustration when you begin talking to her and she cannot respond.
2. Show the elderly person immediately that you do not expect her to speak well, but encourage her to do the best she can.

3. Provide alternate forms for communication such as writing materials and aids the elder can point to.
4. Encourage the elder to use gestures and body language to augment communication.

Techniques for Communicating with the Movement and Tactile Impaired Elderly

1. Be aware of movement limitations in the elderly person.
2. Be aware of pain and its impact on movement of the elderly person.
3. Gestures are effective communication tools particularly with the hard of hearing.
4. Touch is very reassuring and should be used frequently.

Techniques for Communicating with the Cognitively Impaired Elderly

1. Keep your expectations realistic.
2. Keep it simple and go slow; use one step commands.
3. Validate behavior.
4. Reassure and reward.
5. Discover meaning behind behavior.
6. Ask questions that can be answered with a yes or no.
7. Use simple sentences.
8. Don't ask questions that rely on good memory.
9. Don't argue.

Techniques for Communicating with Socio-culturally Diverse Elderly

1. Learn key words in the language of the elderly in your care.
2. Distinguish between translation and interpretation.
3. Avoid use of family members as translators if possible. If family is asked to be interpreters ask them to "translate" rather than "interpret".
4. Learn the beliefs and values regarding respect, nutrition, pain and death of the elderly in your care.
5. Learn key ethnic customs and rituals of the elders in your care.
6. Suspend your stereotypes and prejudice.
7. Use community resources to help in the learning process.

Techniques for Finding Common Ground (Shared Reality)

1. Be sensitive to the elder's self-perception.
2. Look through the patient's prism, not just your professional lens.
3. Suspend stereotypes. Seeing people as individuals suspends our expectations and allows for greater respect and sharing.
4. Develop empathy. Empathy is the ability to see things from the other person's perspective. This is particularly true of understanding the physical deficits that impede communication.
5. Develop flexibility. This is particularly important in relation to our expectations. If these are not rigid, it leaves us open to finding common ground.
6. Be warm and sociable. An open, friendly, respectful manner goes a long way in fostering high levels of comfort.

7. Learn about the language and customs of the elder. The more we know about each other, the better the chance we have of finding common ground.

Additional Useful Techniques when Communicating with the Elderly

1. Think about how you are presenting yourself. Are you harried, angry, or tense? Be calm, gentle, supportive and honest.
2. Be at eye-level when communicating; it creates a sense of shared power and mutual respect.
3. Break concepts down into parts. Give time to consider or accomplish them in order.
4. Don't talk about people in front of them when elders can no longer communicate well.
5. Ask elderly person who he/she wishes to be present when communication about their health is being discussed. If another person is present ask the elder if it is acceptable to speak openly in their presence.

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[*] Gould, Elaine S., MSW, Director for Programs, The John A. Hartford Foundation Institute for Geriatric Nursing, Consortium of New York Geriatric Education Centers 1997-8.

Learning Resource B : The Old Woman: an anonymous poem

What do you see nurses,
What do you see?
What are you thinking,
When you look at me?
Do you see~
A crabby old woman,
not very wise
uncertain of habit,
with far away eyes.
A person who dribbles her food,
and makes no reply
when you say in a loud voice,
"I do wish you'd try"
A woman who doesn't seem to notice
the things that you do,
and forever is losing
a stocking or shoe.
A person, maybe resisting at times,
lets you do as you will,
with my bathing and feeding,
and handing me my pills.

Is that what you're thinking?
Is that what you see?
Then open your eyes nurses,
cause you're not looking at me.

I'll tell you who I am,
as I sit here so still,
as I rise at your bidding,
as I eat at your will.

I'm a child of ten
With a mother and father
and brothers and sisters,
who love one another.
A young girl of sixteen,
with wings on her feet,
dreaming that soon now
a lover she'll meet.
A bride soon at twenty,
the heart gives a leap,
remembering the vows
that I promised to keep.
At twenty-five now
I have young of my own,
who need me to build
a secure, happy home.

A young woman of thirty,
my young now grow fast,
bound to each other,
with ties that should last.
At forty, the young ones are grown
and soon will be gone.
But my man stays beside me,
so I don't feel so alone.
At fifty once more,
babies play round my knee.
Again we know children,
my loved one and me.
Dark days are upon me,
my husband is dead,
I look at the future,
and I shudder with dread.
For my young ones are all busy,
rearing young of their own,
and I think of the years
and the love I have known.

I'm an old woman now,
and nature is cruel.
Nature makes old age
look like such a fool.

The body is crumbled,
grace and vigor depart.
There is now a stone
where I once had a heart.

But inside this old carcass,
a young girl still dwells.
And now and again
my battered heart swells.

I remember the joys,
I remember the pain,
and I'm loving and living
life all over again.
I think of the years,
all too few, and gone to fast,
and I accept the stark fact
that nothing can last.
So open your eyes, nurses,
open them and see,
look a little closer, nurses...
Please~~see the real ME.

Learning Resource C: ON BEING A PATIENT

Letter to a Patient's Doctor

As a journalist who has written about the care of the dying (Life Support: Three Nurses on the Front Line. Little, Brown: 1997), I recently received a letter from a reader, Mr. Richard J, Arthur, whose wife had just died of breast cancer. After some discussion, Mr. Arthur sent me a copy of the following letter, which he had mailed to the physician who had cared for his wife.

Dear Doctor:

First of all, let me state that this letter is being written with love and respect, not as a complaint or anything remotely close to an accusation …

Let me go at it this way.

When you met with Donna and me last March to review the results of the latest bone scan, it was quite obvious that the radiation treatments had failed and that there would be no further medical treatment of the cancer in her spine. But you stood your distance as you talked. And, in fact, you rather shortly dismissed us from the consultation. You will be interested to know that as we left your office Donna's comment to me was that it was harder for you to talk about the test results than it was for us to hear them.

Doctor, a lot of counseling would have been in order right then and there. She, as a terminally ill patient, and I, as the caregiver, needed to know how the disease would progress. We needed to know what the symptoms would be. We needed you to paint a picture for us, give us a sort of scenario about what we might expect to happen. If it had been your decision not to speak of these things in Donna's presence, you could have asked me to come back for the consultation.

I needed to know that as the pain continued to increase there were things that could be done. I needed to know that there would be a gradual lessening of her ability to do things. When she began to have difficulty even standing up and sitting in bed, when she began dropping things, I should have been smart enough to know that things were getting much much worse. Dumb me! I just figured it was part of the ongoing process and nothing to be unduly concerned about.

I needed to know that the effect on her mental abilities would begin to become apparent. Probably the most emotionally disturbing thing that happened was the gradual change in her personality. From a gentle, loving, caring woman she began to change to a hostile, accusatory, even embittered person. At first, I took all this very personally. It took some time before it finally dawned on me that the disease was causing all of these things. I remember somebody asking me how I was doing; I replied I was doing okay, except for all the holes in my tongue from biting it so often and so hard.

Finally, Doctor it would have been tremendously helpful to both Donna and me if you had told us about the hospice program on that March visit. Perhaps you did not think that the time left would be that short, but even so you could have advised me that the program would be available when things got rough.

As it turned out, I finally gave up and phoned you one Friday. You immediately had a hospice nurse come by that afternoon to sign us up. She took charge at once, changing Donna's medication to morphine and adding some other medications. On Sunday an aide came and did much to make Donna comfortable: another aide came to bathe her and trim her nails. The nurse herself came by later, even though it was her day off, just to see how things were going. And Sunday evening, Donna died without really waking up since the night before.

Had Donna been in the hospice program much earlier, I would have been able to secure a lot of assistance in taking care of her. It became increasingly difficult to help her shower and shampoo, and I had a devil of a time trimming her nails and keeping her hair fixed in the ponytail that she loved to wear even at 71 years of age.

I am ashamed to admit how unaware I was of the progress of the disease. I should have been smart enough to realize, as these things began to take place, that the end of Donna's life was coning sooner than I had expected. I don't know why I thought it would be months away. Perhaps after 7 years of being her caregiver, I just assumed it would go on that way indefinitely.

There were many things I could have done differently and better. And there were many things that never got done because I just didn't understand the tine constraints under which we were living. Her children would have spent much more time with her had I been able to advise them about the seriousness of her condition. Because I did not realize it, I failed to alert them, and I know they feel guilty about not having visited more often.

But enough of this discussion. The whole point, Doctor, is to try to motivate you into handling your future terminally ill patients somewhat differently. If you yourself don't feel comfortable with doing the counseling, why not get the patient in the hospice program right away? Those people know how to do it, they are experienced in doing it, and as I could tell even from my short experience with them, do it beautifully.

I can't close this letter without once again thanking you for all of the care you have given us, both Donna and myself, over the years we have been coming to see you. I don't know how much longer I will be your patient because this house is entirely too big and expensive for a single person like me to hang onto and I am
already looking around for a community to which to move. Until then, however, I'll be bothering you for prescription refills and, once in a while, for an office visit.

I hope your vacation was a great one. I know it was past time for you to get away from all of us sick people for a while.

Thanks ever so much for listening,

Richard J. Arthur

Sometime later, I called Mr. Arthur to ask if he had ever received a response from his physician "Not a peep" he replied.

Suzanne Gordon, BA
Arlington MA 02476-7121

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